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The Likelihood of the Establishment of Alien Diseases in the United States*

HARRY S. MUSTARD, M.D.
Professor of Public Health Practice and Director, DeLamar Institute of Public Health College of Physicians and Surgeons, Columbia University

A matter of some concern to the medical profession and the public health authorities of the United States is the possibility that what might be called alien diseases may be imported and established in this country. Is there danger of epidemics of yellow fever, of plague, of cholera, of old world typhus, as a result of an accelerated and far-flung maritime and air travel? Are tropical diseases likely to appear when the Army and Navy are demobilized or as men are invalided back to this country?

Obviously there cannot be any categorical yes or no answers to these questions, for many and complex factors are involved. It is reasonably safe, however, to speculate provided one explores the problem on the basis of well established epidemiological principles. To do this, it is essential to visualize the general epidemiological requirements for prevalence of any communicable disease; to discover within this framework, the specific epidemiological factors that operate in the exotic diseases, and finally to enquire as to the likelihood that the epidemiological requirements for the latter's prevalence may be fulfilled by the conditions that exist or might be brought about in the United States.

In relation to epidemiological principles in general, it may be said that for the establishment of a communicable disease endemically or as an epidemic, three elements are essential. First, there must be present a focus or foci of the disease in question; second, a substantial proportion of the population must be susceptible to that disease; and third, there must be an avenue or channel or means by which the infectious material from the focus may reach the susceptible. A part is played, of course, by virulence of the pathogenic agent, by the age, sex and race, constitution of the population, by season, climate, etc; but these, actually, are subordinate factors; and if any one of the three major elements is missing, the disease cannot establish itself in a given community. When so established, an epidemiological balance is an extremely delicate one. It may tilt in either direction. Thus, in the presence of a susceptible population, a sudden increase in the number of foci of a given disease or a new openness of channels along which its infectious material travels would probably result in an outbreak. On the other hand, in relation to a particular disease, a rise in the immunity level of the population, a lessening of the number of foci, or a decrease in the openness of channels of infection would cause a reduction in the number of cases.

It must be remembered, however, that in an established community, this triad of focus, susceptible and channel of infection is not left to operate along biological lines. Control measures are applied, directed in the one instance to the elimination of foci, in another to blocking or neutralizing the channels along which infectious material may travel or in converting a susceptible population into a relatively immune one. As a matter of fact, all three measures are usually instituted simultaneously, within the respective limits of their applicability. Obviously, times does not permit a detailed consideration of all such diseases as cholera, plague, yellow fever, typhus, amebiasis, bacillary dysentery, malaria, trypanosomiasis, filariasis, leishmaniasis, schistosomiasis, etc. But this mere enumeration of a few of them leads immediately to a realization that foci of some are already present in the United States, that the majority of them are insect borne; that insect vectors of some of these diseases are relatively abundant in many parts of the United States. Another element of importance, on the debit side, is that our population as a whole is quite sus-

*Read before the meeting of the South Carolina Medical Association at Columbia, South Carolina, April 12, 1944.

ceptible to these tropical and alien disabilities.

The next point to explore is the possibility that new or additional foci of these various diseases might be introduced, or that new or more effective vectors could be imported, and what might be the result if this happened. Perhaps new foci may come from persons who visit or live in the tropics; new vectors or infected vectors might be introduced by the recent spanning of the world by airways. We have, or will have some millions of soldiers, sailors and marines in areas where such diseases as cholera, old world typhus and scrub typhus, plague, yellow fever, filariasis, are or recently have been endemic. But all troops will have been more or less effectively immunized against those diseases for which vaccines are available; and too, within the limits of field and combat conditions, our troops' environmental protection will be fare greater than that of most of the populations native to the areas. Assume, however, that in spite of all precautions, some of our troops contract one or the other of these exotic diseases. Compared to the hundreds of thousands exposed, there is every reason to believe that the number infected will be quite small. Cases that do arise will be treated in military hospitals or rest areas in the war theaters concerned or will be brought back to this country for further care by medical officers. Most of them will have recovered, and will have passed their period of communicability long before they get back home. Certainly they will not be discharged as long as they are in a stage where the disease might be transmitted to others. Undoubtedly, some cases of malaria will relapse after discharge, and some men, supposedly recovered from amebic dysentery, will later develop liver involvement. On the whole, however, it seems unlikely that returning troops will serve as a focus of spread of the truly alien tropical diseases. But it is possible that individual cases of such diseases may appear after the war from sources other than the military. Reference is here made to an increasing travel between this and tropical countries. Alliances, treaties, national policies, and trade interests will more than ever carry government officials, business men, technical advisors into places whose names they could not have pronounced two years ago. They go, and probably will continue to go by ship and by airplane to the uttermost corners of the earth; and tourists will go down the Pan-American highway to Mexico, Central and South America. In the same way, people will come from these various places to this country, some of them for treatment of a well-established tropical disease; occasionally, perhaps, one in the pre-clinical or carrier stage of a disease potentially able to assume epidemic form. Or some ship or car or plane might bring in an insect as dangerous as dynamite. What happens then?

Perhaps one may best answer this by speculating as to one or two specific diseases. Consider, for this purpose, yellow fever. This is a disease with which the Atlantic and Gulf coasts and some inland areas had long and harrowing experiences in the 18th and 19th centuries. What are the chances that yellow fever might come back to its old haunts? Examine the question in terms of foci, agents of transmission, and susceptibles. In regard to the last, it may be said that with the exception of those who have been vaccinated against yellow fever, and with the further exception of a few ancients who had the disease two generations ago, the whole population of the United States is susceptible. In relation to agents of transmission, it must be confessed that they are abundant, in the form of *Aedes aegypti* mosquitoes, normally found in the southern United States and occasionally quite far north. So far as concerns this disease, then, there are already present two out of three of those factors upon which epidemics are built. The absence of outbreaks since 1905 is due to the fact that foci have been entirely lacking or, if they have been imported, the chain from case to insect to susceptible has not been completed.

If effectively operating foci were introduced, the ingredients for an epidemic would all be present. Even assuming this, however, it is unlikely that an epidemic of yellow fever would be precipitated. The natural history of the disease gives some protection in that, in ordinary circumstances, the individual with yellow fever may infect the biting mosquito only during the first three to five days of illness, and the virus must then undergo, in the mosquito, an extrinsic period of incubation of from 4 to 18 days, with an average of 12 days. After this there would ensue the intrinsic or human period of incubation, some 2 to 6 days, before the newly-bitten person would become ill. In other words, there would be a little more than 2 weeks between the first case and the explosion of secondary cases. It is exceedingly doubtful, however, that there would be more than a small group of secondary cases, for on the appearance of one case or of a number of cases, competent control measures would immediately be put into operation by state and local health agencies. On this point it should be emphasized that although many physicians take their health departments for granted (when they are not taking them to task), the modern health department is a highly efficient mechanism. Comforting, too, in this connection is the fact that the United States Public Health Service has quietly but efficiently established at various strategic points in the southern and eastern United States, complete organization and equipment for yellow fever control. Trucks remain constantly packed, personnel has been designated and specially trained on a unit basis for *Aedes aegypti* destruction. A half dozen telegrams from the Surgeon General of the Public Health Service would cause the trucks to roll and an immediate convergence of trained workers at the point endangered. Further, there are ample stores of yellow fever vac-

cine which provide quite effective protection in about ten days and this, of course, would be utilized to convert the threatened susceptible population into an immune one. The following, then, may be said with fair safety: First, that while it is possible that either a case of yellow fever or an infected mosquito might get through the present barriers, it is quite unlikely that this will happen; second, that though the population is quite susceptible to yellow fever, this situation could be changed very quickly; and third, that though the vector, *Aedes aegypti*, is abundant in the southern and eastern United States, highly effective control measures are practicable in any area that might be concerned.

It might be profitable now to consider the potentialities for spread of a non insect borne disease, cholera. Cholera has not been epidemic in the United States since shortly after the Civil War. This country, though, suffered rather devastating epidemics of it in 1832, in 1849 and for some years thereafter, and in 1873. There were a small number of cases imported into New York City in the late 90's, but there was no real spread from them. Cholera at present prevails extensively in India, China and other parts of the Orient, and is found in moderate outbreaks in some areas of South America. It is conceivable that some among our troops might become cholera carriers, or that on the resumption and increase of world travel, infected natives of other countries might get into this one and thus supply one element of the necessary focus, avenue of infection, and susceptible triad. It may be said, however, that while our resident population is quite susceptible to cholera, so far as is known the avenues of infection along which cholera ordinarily travels are rather thoroughly blocked in all well-organized communities. Although an outbreak of cholera may be kept alive and spread across a country as a result of direct contact infections, the initial outbreaks, explosive in nature and involving large numbers of people, arise essentially from infected drinking water, and when the focus is imported, usually arise in seaports. In the United States, with as high a proportion of safe and protected water supplies as in any nation in the world, it is extremely unlikely that a disease disseminated as is cholera, would gain a serious foothold. Even though such a foothold were established temporarily in one place or another, the subsequent history would essentially be that of typhoid fever; a reduction to a minimum residue or complete elimination in urban areas, with occasional sporadic or endemic episodes in those areas not protected by sewer systems and supervised common water supplies.

Time does not permit further discussion of these alien diseases in detail. The insect vectors of many of them are absent from this country and climatic conditions here are quite unsuitable to them. However, one may consider the probabilities or improbabilities of the spread of some other so-called tropical diseases already present, should something occur to tip the present epidemiological balance. In relation to malaria, it may be said that the area in which this disease was once endemic has receded markedly in the past fifty years. On the other hand, many places now malaria free, still have malaria vectors present. Should individuals, with gametocytes in the circulating blood, take up residence in these *Anopheline* areas, a local outbreak of malaria might be precipitated. Further, there is the possibility that new strains of malaria might be brought in or that there might be introduced new species of *Anopheles* more effective as vectors than those whose normal habitat is this country. This happened some years ago in the northern part of Brazil when the rather vicious and competent *Anopheles gambiae* was imported from the western bulge of Africa.

Another already present disease that one must consider is plague. This country has for some time had a potentially dangerous situation as regards this disease, for examination of squirrels, prairie dogs, etc., indicates that these animals or their parasites are infected with plague in extensive areas of the West, extending from the Pacific coast well into Wyoming, New Mexico, and to some extent Colorado. Only very rarely, however, have human cases arisen from these foci, seemingly because man's contact with wild rodents is not very intimate, though other factors may contribute to the absence of human cases. The infected rat in a city is the usual focus from which bubonic plague epidemics begin; and infected foreign rats, or even infected country rats, visiting our seaports or other cities, could cause trouble. This is a situation that might well be watched. The foci, and even the transmitting insects are present, but the epidemiological chain for some reason is not quite complete.

The experience with filaria in Charleston, S. C., has been such as to give hope that even though individuals infected with this disease return from tropical areas and go to the stage of microfilaria production, it is unlikely that there will be more than occasional and sporadic transfer. The disease appears to build to an endemic level slowly, establishing itself only under unusual circumstances. It remains at a high level only when there is a parallel plentifulness of cases and vectors. With the institution of effective anti-mosquito measures, the number of potential vectors is lessened; and with fewer new infections occurring, and with old ones dying off or becoming non-infective, the incidence of the disease decreases by geometric progression. It is not, therefore, probable that newly-introduced cases in other parts of this country will establish the disease. It is not even likely that those recently infected in the tropics will become chronic cases. This refers essentially to that form of filariasis produced by the *Wuchereria bancrofti*. There is another form of filariasis, however, common in Africa and now appearing in certain parts of southern Mexico and the

northern part of Guatemala. This is that form known as onchocerciasis, due to the *Onchecerca volvulus*, causing fibrous nodules in the skin, and not infrequently, blindness, when the microfilaria make their way to the eye. The transmitting agent in this instance is the *Simulium* or buffalo gnat of which there are a great many species. *Simulium* is world-wide in its distribution and one must at least entertain the possibility that some of the species in the United States might act as satisfactory vectors. The difficulties of controlling *Simulium* have been almost insurmountable.

Important in this whole matter of insect-borne disease is the fact that recent developments of new larvacides and agents lethal for insects bid fair to change man's entire relationship to this form of life. Almost fantastic stories are told of the efficacy of such insecticides as D. D. T. Consider the plaint of the sanitary engineer who tried to measure the efficacy of it by studies of a dosed pond on the one hand and a control pond on the other. He found himself completely frustrated because a duck, flying from the first pond to the second, took on his feathers enough of the larvacide to kill all of the larvae in the undosed pond. Consider, too, the story that after a barn is painted with solutions containing these new substances, any fly that lights on the wall drops dead with immediateness and permanency. Doubtless these are exaggerations, but there is enough solid truth to offer great promise for insect control. There is the danger, of course, that such a powerful agent might upset the whole biological balance and lay man open to new hazards, but that is another story.

This seems as far as one may go profitably in a discussion of the subject. The general indications are that though one must admit the possibility that foci of alien diseases may be introduced, or that in relation to diseases already present more effective vectors may be introduced, it is exceedingly unlikely that such diseases would reach epidemic proportions in the United States. One gets considerable comfort from the knowledge that in such diseases as these it is not difficult to break epidemic chains by applying control measures severally or coincidentally to foci, avenues of infection and susceptibles.

Trends of Immunization in Present Day Pediatrics

M. W. BEACH, M.D., AND B. O. RAVENEL, M.D., CHARLESTON, S. C.

(Delivered at Annual Meeting, S. C. Med. Assoc. Columbia, April 12, 1944.)

The Author:
Dr. Beach is Professor of Pediatrics at the Medical College of The State of S. C. He was graduated from this institution in 1913.
Dr. Ravenel is Associate in Pediatrics at the Medical College. He was graduated in 1939.

When the chairman of your program committee requested that I present a paper on "Trends of Immunization In Present Day Pediatrics" I accepted his invitation with a great deal of trepidation, for in recent years we have seen many changes in the former methods of immunization which had produced accepted results. The results which had been obtained by these procedures however, were somewhat disappointing, for while we were able to establish a state of immunity, we also produced undesirable conditions in our patient. Most of us recall the excellent results obtained with the injection of toxin-antitoxin in establishing an active immunity against diphtheria, but at the same time a high degree of sensitivity to horse serum was developed. Then if it became necessary to administer an antitoxin which contained horse serum, the patient very often developed a severe serum sickness or anaphylactic shock. There were some deaths. Therefore, workers in this field realized that basic changes must be made, antigens reconstructed, and procedures shifted and modified to fit new patterns, if we were to progress toward the Utopian state of immunity. Dr. Edward Jenner, Dr. Benjamin Waterhouse, and Dr. John Redmond Cox were the pioneers in this field and contributed to the foundation upon which modern preventive medicine has developed.

In discussing trends of immunization in present day pediatrics we intend to present some of our own views as well as those of other writers recently published in medical journals. If we keep in mind some of the simple facts concerning this subject we will easily grasp the idea which we are attempting to develop. Therefore, we will say that the ability to resist infection is due to immunity, and immunity is that unknown quantity which protects an individual from contracting certain diseases when exposed to the ordinary dose of the exciting agent. When an unprotected individual is exposed in the same way he will contract the disease. There are three types of immunity — innate, conferred and acquired. In this brief discussion we will deal

IMMUNIZATIONS FOR THE FIRST YEAR

1. Birth to three months
   Vaccinate against smallpox using cowpox virus

1941	Morbidity	Mortality
U. S.	1,368	12
S. C.	10	0

Morbidity rates from U. S. Public Health Reports
Mortality rates from Vital Statistics of U. S.—1941

principally with the acquired type.

A new baby is born and the anxious parents immediately begin to plan for its future welfare. The parent's concern is always the same — how to keep their baby well. This is the time to instruct them in various health measures and to inform them of the value of immunizing their baby against certain diseases. This is a health proposition which concerns the well-being of the individual and the future place he will occupy in society. Therefore, we advise that he be inoculated with cow-pox vaccine. The time when this procedure apparently causes least infection and disturbance is during the nursery period, or about the end of the third month. If the vaccine is potent we may expect a high percentage of takes at this age. Also, since there is less infection, the scar is smaller and gives a more pleasing cosmetic effect. Some parents think that it is very important to select an appropriate site. However, in these modern days the site is unimportant and the middle third of the left upper arm is quite satisfactory. The procedure in general use is as follows: Clean the selected site with soap and water, ether, acetone, or 70% alcohol. Allow to dry thoroughly and then place the contents of a clean capillary tube on the site. Hold the skin a little tense, then with a sharp sterile needle held tangenized to the site, exert gentle pressure through the vaccine drop with sufficient force to puncture the skin, but not enough to cause bleeding. Repeat 15 or 20 times. This will cause a small excoriated surface. Allow the punctured surface to thoroughly dry and the wounds will be automatically sealed. With the proper instructions to parents and patient it is not necessary to cover the wound with a sterile dressing. If you do not get a successful take, the procedure should be repeated in two weeks. A patient who has been successfully vaccinated should be again inoculated at the fifth and fifthteenth year. If immunity is established it may endure through life.

The first phase of the immunization completed, we are going to use a different strategy and plan our attack with a combination of antigens. Now it is possible to give two or more different types of antigens which have been combined in a stable, standardized mixture of tested potency. When these mixtures are used immunity is established at a higher level than it is possible to produce by using a single antigen. However, the patient is more liable to have a severe reaction and the possibility of necrosis is increased. This is quite noticeable when the pertussis antigen is combined with those of tetanus and diphtheria. These difficulties will be overcome in the near future and a satisfactory multiantigen will be developed. In the meantime, however, we believe that the infant should receive the first dose of standardized pertussis vaccine (15 to 20 billion organisms per c. c.) at five months of age. This dose is given in the prepared subcutaneous tissue of the middle third of the left upper arm. The second dose of 2 c. c. and the third of 3 c. c. are to be given in like manner. The time interval between doses should be 30 days or more. The arm will receive alternate doses. It will take about four months for the infant to develop sufficient antibodies to protect him against pertussis. Therefore, while he is building up this immunity it is imperative to keep him from infective cases. Some writers claim that they can establish immunity in 80 to 90% of their patients. I have not been able to reach this goal, but am convinced of the value of the procedure. It is regrettable that there is not a simple, accurate method of determining the status of immunity acquired in this way. However, in the experimental stage, there is a simple macroscopic agglutination test which offers some hope of future development. The test is carried out by mixing a drop of blood and an equal amount of antigen solution on a piece of white paper. Make a thin smear and allow to dry. If the patient is immune or has developed pertussis the antigen will be agglutinated. If this test should prove worth while it may open up a new phase in early diagnosis and in establishing the immunity quotient of patients who have received the pertussis vaccine. Then it would be possible to determine the rational for the yearly "booster dose" of pertussis vaccine which should be given over a period of years.

From recent experimental and clinical research we now have a satisfactory alum precipitated toxoid which contains the antigens of diphtheria and tetanus but whose concentration is subject to the manufacturer. Therefore it is very important that you should note the dose recommended by each pharmaceutical house. We are using these combined antigens as an immunizing agent against these two

2. Fifth, Sixth and Seventh Months
   Inoculate against pertussis using Phase 1 H. Pertussis (15,000-20,000 million killed organisms per c. c.) — 1 c. c. Initial dose — 2 c. c. second dose — 3 c. c. third dose given subcutaneously 1 month or more apart.

1941	Morbidity	Mortality
U. S.	221,590	3785
S. C.	5,020	208

3. Eighth, Tenth and Twelfth Months

Inoculate against diphtheria and tetanus using combined diphtheria-tetanus toxoid-alum precipitated. Give according to recommendation of manufacturer in 3 doses two or three months apart.

	Diphtheria		Tetanus	
1941	Morbidity	Mortality	Morbidity	Mortality
U. S.	17,939	1,293	426	602
S. C.	1,843	10	33	8

diseases. By now the little patient is eight months old and it is time to inoculate him with the first dose of these combined antigens. We select and prepare a new site on the upper arm and inject subcutaneously 1 c. c. of the specific alum precipitated toxoid. There will be some inflammatory reaction at the site and a moderate degree of fever which usually subsides in 36 hours. The local induration remains for 2 or 3 months and occasionally may cause necrosis. This antigen is very slowly assimilated and for this reason it is evident that a second dose is unnecessary until the first has been utilized. Therefore the interval between doses should be 3 months. The second dose is injected in the same manner as the first. Others prefer to use ½ c. c. of the combined antigen for the first dose and 1 c. c. for the second and third doses. Two doses of antigen given in this fashion should establish more than 90% of immunity. It should be a routine procedure to do a Schick test within six months after inoculation has been completed to determine whether or not immunity has been established. Reimmunize if necessary and thereafter give yearly "booster doses" during the pre-school age. The procedure necessary to determine immunity against tetanus is more complicated. When an immunized individual is exposed subsequently to possible tetanus germs, inject 1 c. c. of alum precipitated tetanus toxoid. Do not give tetanus antitoxin. It is a great comfort to the infant's parents to know that he is approaching his first birthday with the four most important immunizations completed.

The second year of this little patient's career is at hand. He is now in the midst of the runabout stage and we find him alert and anxious to fathom some of the mysteries which are going to play the leading roles in the development of his individuality, independence, stability, and character. He is unaware of other diseases which can obstruct the pathway with the wreckage of health. Therefore, during the first half of the second year we will begin a new phase of immunization for his protection. This is an opportune time to inoculate him with typhoid vaccine. The triple typhoid vaccine is ideal for this purpose and ¼ c. c. is used for the first dose, ½ c. c. for the second and third doses. The mode of administration should simulate the previous method used in his immunization technique. The interval between doses should be four weeks. There is some local reaction about the site of injection which often persists for 2 or 3 weeks while the vaccine is being slowly assimilated. The constitutional symptoms are usually mild and subside in a few days. About 6 months after the third dose has been given it is advisable to determine the amount of immunity by use of the Widal test; then give a "booster dose" of vaccine each spring as a wise precaution.

Unless some emergency should arise, we refrain from any passive or active immunization during the remainder of the second year. At the same time we realize that scarlet fever begins to be more prevalent at about the third year, therefore this disease should receive due consideration. This is particularly true in certain urban areas and especially during the school season. Scarlet fever may become quite a public health problem. In these communities the tempo of scarlet fever suddenly changes and most of the cases are of the severe type with high fever, vomiting, marked angina, prostration, rapid pulse, and marked erythema, which increase the possibility of severe complications. This makes it evident why a child who lives in such an urban area should be immunized and why this procedure should be carried out during the first half of the third year. There are many methods used to accomplish this purpose, but the one suggested by Young and Orr is simple and establishes more than 90% of immunity. They recommend that 500 skin test doses of standardized scarlet fever toxin be administered subcutaneously for the first dose, 5,000 for the second, and 30,000 for the third, and that the doses be given at intervals of three weeks. The Dicks use 650, 2,500, 10,000, 30,000, and 100,000 skin test doses. The degree of established immunity may be ascertained by the Dick test.

Sometimes it is imperative that an attempt be made to establish active immunity against typhus fever, Rocky Mt. fever, yellow fever, rabies, tuleremia, etc., but as a routine procedure this is unnecessary.

It would hardly be in keeping with the subject should be fail to mention the value of transferred immunity which can be given through the medium of sera. Convalescent human serum has been used very extensively in the past few years and with this serum it is possible to ameliorate or prevent measles, mumps, chicken pox, scarlet fever, and

IMMUNIZATIONS FOR SECOND YEAR

1. Schick test six months following last diphtheria tetanus toxoid injection.
2. Triple typhoid vaccine — three doses, ¼ c. c., ½ c. c. and ½ c. c. — injected subcutaneously one month apart.

1941	Morbidity	Mortality
U. S.	8,485	1,022
S. C.	254	54

IMMUNIZATIONS FOR THIRD YEAR

Immunize against scarlet fever—using scarlet fever toxin.

Method of Young & Orr—3 doses
1st. 500 s.t.d.
2nd. 5000 s.t.d. 90% Immunity
3rd. 30,000 s.t.d.

Method of Dick—5 doses
650 s.t.d; 2500 s.t.d.;10000 s.t.d.; 30000 s.t.d.; 100,000 s.t.d.

	1941	Morbidity	Mortality
U. S.		128,518	454
S. C.		50	5

other diseases. Therefore, it would be wise to ever be mindful of the potentialities and the possibilities of immunization in the effort to conquer diseases.

BIBLIOGRAPHY:

Abt, A. F. *Prophylaxis For Contagious Diseases.* Medical Record & Annals, 36:367, July, '42.

Barenberg, L. H. et al. *Prophylactic Use Of Human Serum Against Contagion In Pediatric Wards: Further Observations.* American Journal of Diseases of Child., 63:1101-09, June, '42.

Bergz, G. A. *Recent Developments.* (Immunology). West Virginia Medical Journal, 39:52-55, Feb., '43.

Bloom, C. J. *Immunization In Pediatrics.* Southern Medical Journal, 36:495-503, July, '43.

Brescia, M. A. *In Infancy, Including Comparative Study Of Schick Test In 200 Mothers and Their Infants.* Archives Of Pediatrics, 59:513-524, Aug., '42.

Bull, H. G. *Prevention of Common Type of Diphtheria Use of Single Dose of 1½ c. c. of Alum Precipitated Toxoid.* Archives Of Pediatrics, 59:397-399, June, '42.

Pertussis Vaccine (4 to 7 Years Later). Archives Of Pediatrics, 58:764-768, Dec., '41.

Cappolino, J. F. *Pertussis Prophylaxis: Clinical Study.* Journal Of Pediatrics. 21:348-352, Sept., '42.

Castaneda, M. R. *Bivalent Vaccine of High Immunizing Value.* Science, 96:304, Sept. 25, '42.

Collins, S. D. & Councell, C. *Extent of Immunization & Case Histories for Diphtheria, Smallpox, Scarlet Fever & Typhoid in 200,000 Surveyed Families In 28 Large Cities.* Public Health Report, 58:-1121-1151, July 23, '43.

Committee For Study For Social Medicine: *Diphtheria Immunization In England & Wales: Statistical Study Of Reactions & Difficulties Of Mothers.* Lancet, 2:642-646, Jan. 23, '43.

Daughtry-Denmark, L. *Whooping Cough Vaccine (including combinations with diphtheria and tetanus toxoids.)* American Journal of Diseases of Child., 63:453-466, Mar., '42.

Dyson, J. E. *Diphtheria Prevention.* Journal Iowa Medical Society, 33:101-102, Mar., '43.

Enders, J. F. *Immunity,* Annals Of Internal Medicine, 18:1015-1019, Feb., '42.

Felton, H. M. & Flosdorf, E. W. *Clinical Results With Use Of Agglutinogen From Phase 1 Hemophilus Pertussis As Skin Test For Susceptibility.* Journal of Pediatrics, 22:259 264, Mar., '43 & 21:625-634, Nov., '42.

Firar, W. M. *Collective Review.* International Abstrasts of Surgery, 75:185-190, 1942.

Fisk, C. *Active Immunization.* Journal Iowa Medical Society, 33:103 105, Mar., '43.

Fraser, D. T. et al. *Tetanus Toxoid and Its Use for Active Immunization (With special reference to T. A. B. T. typhoid-paratyphoid-tetanus vaccine).* American Journal Pub. Health, 33:1107-1114, Sept., '43.

Freund, I. Bonanto, M. V. *Effect of Amount of Antigen On Antitoxin Formation During Primary and Secondary Immunizations.* Journal of Immunology, 45:71 78, Sept., '42.

Garrett, G. A. *Diphtheria During Immunization.* British Medical Journal, 1:102-103, Jan. 23, '43.

Ghosh, H. *Immunity Response to Nonspecific Antigens.* Journal of Indiana Medical Ass'n., 11:100-103, Jan., '42.

Gold, H. & Fitzpatrick, F. *Typhus In Previously Vaccinated Laboratory Worker.* Journal American Medical Ass'n. 119:1415-16, Aug. 22, '42.

Graham, H. C. *Immunization: Dick's Injection Method.* Journal of Oklahoma Medical Ass'n., 35:335-340, Aug., '42.

Evaluation of Methods of Immunization Over A 15 Year Period. Southern Medical Journal, 35-132-139, Feb., '42.

Hayne, A. L. *Modern Methods of Control for Measles, Scarlet Fever and Diphtheria.* Minnesota Medicine, 26:167-170, Feb., '43.

Hyland, C. M. *Convalescent Human Serum Therapy.* Rocky Mountain Medical Journal, 39:679-683, Oct., '42.

Jones, B. B. *Resistance to Disease in Childhood.* Southern Medical Journal, 36:442-449, June, '43.

Jordan, C. F. *Prophylactic Procedure for Communicable Diseases.* Journal Iowa Medical Society, 33:107-108, Mar., '43.

Landis, J. H. *Reaction From Toxoid.* American Journal Diseases of Children, 65:519, April, '43.

Lapin, J. H. *Combined Immunization Against Diphtheria Tetanus and Whooping Cough.* American Journal of Diseases of Children, 63:225-237, Feb., '42.

Vaccines. Journal of Pediatrics, 22:452-58, April, '43.

Leibovitz, A. *Comparative Study of Intradermal and Subcutaneous Methods for Vaccination.* Yale Journal of Biology & Medicine, 15:609-614, Mar., '43.

Longfellow, D. *Vaccine Studies: Production of Cross-Immunity Between Members of Typhoid Paratyphoid Group of Micro-Organisms.* Journal of Immunology, 45:249-260, Dec., '42.

Luippold, G. F. *Vaccine Studies: Relationship Between Antigenic Content & Immunogenic Properties of Bacterial Suspensions.* American Journal of Hygiene, 36:354-361, Nov., '42.

Melnick, T. *Active Immunization.* Archives of Pediatrics, 59:90-98, Feb., '42.

Miller, J. J. & Saito, T. M. *Concurrent Immunization Against Tetanus, Diphtheria, and Pertussis: Comparison of Fluid and Alum-Precipitated Toxoids.* Journal of Pediatrics, 21:31-44, July, '42.

Miller, J. J. et al. *Agglutinative Reaction For Hemophilus Pertussis: Persistence of Agglutinins After Vaccine.* Journal of Pediatrics, 22:637 643, June, '43.

Naumer, H. A. & Nerb, L. *Reactions & Agglutinin Responses To Various Methods of Immunization.* Archives of Pediatrics, 60:63-68, Feb., '43.

Naupert, C. N. *New Prophylactic Measures.* Wisconsin Medical Journal, 42:916-918, Sept., '43.

Neubauer, C. *Clinical Signs of Diphtheria In Inoculated Children.* Lancet, 2:192-194, Aug. 14, '43.

North, E. W. & McGuinnes, A. C. *Antigen Struc-*

ture of Hemophilus Pertussis & Its Clinical Significance. American Journal Diseases of Children, 64:43-50, July, '42.

Opie, W. H. *Prophylaxis of Measles (using Imune serum).* South African Medical Journal, 16:168, Apr. 25, '42.

Palmer, T. M. *Modern Methods of Immunization.* Journal Florida Medical Ass'n., 28:330-333, Jan., '42.

Peshkin, W. M. *Immunity Induced by 3rd Dose of Toxoid 2 Yrs. After Basic Immunization; Study of 31 Allergic Children.* American Journal Diseases of Children, 65:873-881, June, '43.

Tetanus: Immunization To Tetanus Induced By A 3rd Dose of Toxoid Three Years After Basic Immunization . . . A Study. . . . American Journal Diseases of Children, 67:22 29, Jan., '44.

Phair, J. J. *Immunization: Interpretation of Schick Test.* American Journal of Hygiene, 36:283-293, Nov., '42.

Philipps, P. & Anerson, C. W. *Preventive Inoculation: Apparatus and Methods.* Practitioner, 148:-364-368, June, '42.

Report of Council on Pharm. & Chem. *Human Convalescent Measles Serum & Human Convalescent Scarlet Fever Serum.* Journal American Medica' Ass'n., 121:49-51, Jan. 2, '43.

Schmeckebier, M. M. *Variation In Anti-toxin Titers Of Human Serum: Report Of Extended Study, With Special Reference To Endocrine & Vitamin Relationship.* American Journal Diseases of Children, 66:25-36, July, '43.

Schwentker, F. F. et al. *Immunity.* American Journal of Hygiene, 38:27-98, July, '43.

Smythe, A. M. *Immunization Procedure.* Journal Iowa Medical Society, 33:102-103, Mar., '43.

Stebbins, E. L. *Epidemiology (Relation To Immunity).* Medical Clinics of North America, 27:651-660, May, '43.

Stokes, J. H. et al. *Results Following Inoculation Of Children With Egg-Passage Measles Virus.* Journal of Pediatrics, 22:1-16, Jan., '43.

Toomey, J. A. & Fischer, L. A. *Typhoid-Para-Typhoid Vaccine.* American Journal Diseases of Children, 66:12-15, Aug., '43.

Toomey, J. A. et al. *Relation Between Amounts of Antigen Injected & Production of Agglutinins.* Journal of Laboratory & Clinical Medicine, 28:835-42, Apr., '43.

Toomey, J. A. *Immunization.* Annals of Internal Medicine, 15:959 973, Feb., '42.

Symposium On Pediatrics: Appraisals of Immunization Procedures. Clinics, 2:323-340, Aug., '43.

Active Immunity: Preventions Against Smallpox, Diphtheria, Whooping Cough, Tetanus & Typhoid. Journal American Medical Ass'n., 119:18-25, May 2, '42.

Wall, J. S. *Communicable Diseases of Children: Prevention.* Medical Annals of the District of Columbia, 11:428-438, Nov., '42.

Wychoff, C. W. *Prophylaxis In Pertussis.* Ohio State Medical Journal, 38:1122-1126, Dec., '42.

Typhus Immunization. Intervation Medical Digest, 40:186 188, Mar., '42.

Active Immunization. International Medical Digest, 40:121-124, Feb., '42.

Agglutionative Reaction For Hemophilus Pertussis. Journal of Pediatrics, 22:644-651, June, '43.

Comments on the Ten Point Program

From W. R. Wallace, President, S. C. Medical Association:

Right now a good setup could do worlds of good for organized medicine. Facts could be assembled and tabulated and put in readable, and usable forms for the truly interested statesmen, the members of legislature as well as the profession itself. After this ground work has been done we might be able to carry on in a less expensive way through your office. Let's make another effort to carry out the original plans adopted by the Council.

From W. T. Brockman, President-Elect of the S. C. Medical Association:

The Ten Point Program offers an opportunity for organized medicine to experiment safely without anyone being hurt financially. We can at least try this plan and we will learn the things to stick to and discard.

From Frank Cain, Chairman of Council:

You received some weeks ago a letter from our Secretary relative to the proposed Ten Point Program to be studied and put into effect by our Association, if found to be feasible and advisable. If you are interested in this study, you will personally, please, make a contribution. Unless Council can raise five thousand dollars ($5,000.00) from the members it will be absolutely impossible for Council to attempt any study of the problems involved. The House of Delegates instructed Council in this matter, but no provision for financing was made. Council looks to the individual members.

The Journal of the South Carolina Medical Association

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Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

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A $500 BOND

Each physician in South Carolina is asked to buy the minimum of $500 worth of War Bonds during the months of June and July.

This is not only the privilege of every physician, it is his duty.

THE OTHER EIGHTY PERCENT

On April 26, a letter was sent to each member of the Association, telling of the Ten Point Program which had been adopted by our House of Delegates and the method of putting it into operation as outlined by our Council. Each member of the Association was asked to send in a contribution of $15.00 or more to activate the program. Council has declared that at least $5,000 must be raised before we can safely launch out upon this new venture.

Two months have passed and contributions have been received from only twenty percent of our paying members. But what of *the other eighty percent?*

The Ten Point Program will not be put into operation until the money is at hand. It should be in operation now—but it is not. To wait longer is to give credence to the belief of many that the doctors don't know what they want—and if they do, they refuse to let the public in on the secret.

The South Carolina Medical Association can forge to the front and show the people of this state and of the nation what a determined medical organization can do—or it can sit by and take the medicine which some politician or would-be-reformer has in store for us.

It all depends upon *the other eighty percent.*

GOOD OLD SUMMERTIME

"In the good old summertime," the thoughts of all of us turn toward a vacation. But with the press of work and the call of duty being as persistent as the are, many are hesitant about embarking upon any period of rest and relaxation.

Feeling as we did a year ago, we take the liberty of reprinting the editorial on this subject which appeared at that time:

Should physicians — during this time of stress and relative doctor shortage — plan on taking vacations this summer?

Should anyone wish to debate this question, we would be glad to take the affirmative. Yes, by all means, physicians should plan to vacations this summer.

It is the rare physician in South Carolina who has not worked harder these past twelve months than he has in any recent years. Not since the influenza epidemic of 1918 have physicians as a whole had as much to do. And next year promises to be a duplicate of the last.

Physicians, as a rule, have stood the test and stood it well. So far as we have heard, there have been no breakdowns from overwork—but then it must be remembered that doctors are noted for being able to toil for long hours and not only stand it but apparently thrive on it.

Physicians, however, are still built of human stuff. All work and no play not only makes a dull boy but in certain instances it makes a sick boy—particularly when that work carries with it loss of sleep and emotional strain. The human body can stand so much abuse and then needs a period of rest and repair—as any sensible doctor knows.

For the sake of our bodies, our minds, our nerves, and our patients we advocate the following program for the summer season to fit us for the months ahead;

1. One afternoon each week out of doors away from a telephone.

2. One or two weeks of complete and thorough vacation—where the sun shines, the waves roll, the fish bite, the fairways beckon, and the stethoscope and scalpel are left behind.

THE A. M. A. MEETING

(A Travelogue)

Leaving Florence on Friday night, I went to Washington, spent a few hours with two of my brothers and headed for Chicago, arriving on Sunday. This allowed for a little loafing and a good night's sleep before the meeting actually started.

Monday, June 12.

It's hard to teach an old dog new tricks and I

found myself awake at the usual time — and Chicago has Central time which is an hour behind our South Carolina time. A possible hour of sleep completely gone!

After breakfast in the Coffee Shop of the Bismarck Hotel (where I stayed), I walked the six blocks to the Palmer House, meeting place of the House of Delegates. While registering and waiting for the crowd to come in, I looked around and found several friends: William Weston, Sr. and Tom Pitts of Columbia, Stanley Weld, Editor of the Connecticut Medical Journal, J. Bouslog, Secretary of the Colorado State Association, Harvey Stone of Baltimore, Alf Walker, pediatrician from Birmingham, W. C. Davison of Duke, Ted Wiprud, Executive Secretary of the Medical Society of D. C., and Lombard Kelly, formerly of Augusta and now Secretary of the Council on Medical Service and Public Relations.

"Dave" Davison of Duke told an amusing story on himself. Waking up early he decided to catch up on some writing. Finding the room hot, he attired himself in a pair of shorts and sat before his desk. Shortly, the phone rang and a voice said, "A complaint has been called in that there is an undressed man in your room and the shade has not been pulled." Dave's conclusion is that there must be some very good blue-nosed individuals in Chicago.

Watching the crowd assemble, I was again struck with the number of gray-haired and bald-headed men present.

The first item of business was the selection of a man to receive the annual Distinguished Service Medal. Three names were proposed: Arthur Abt, pediatrician of Chicago, George Dock, internist and pathologist of Pasadena, California, and Simon Flexner, pathologist and researcher of New York. Dr. Dock was elected on the second ballot.

Harrison Shoulders, Speaker of the House, then gave his annual address and appointed the Reference committees. So much of the work is done by these committees that they are extremely important. Any resolution or report presented to the House of Delegates is referred to one of these committees and no action is taken until the committees have had a chance to study them. This method helps a great deal by confining most of the argument to small groups rather than to the entire House. It's one great drawback is that some good ideas are killed "unborn" in the hands of a hostile committee.

About this time, Tom Pitts called me out and we put the final touches on the resolution which our South Carolina House of Delegates sent up relative to making the number of delegates to which each state association is entitled, two instead of one. While we were working, Buck Pressly made his appearance.

The next report was that of James Paullin, President-Elect of the A. M. A. He began with a presentation of various post-war problems for which plans were already being made. He discussed the serious situation which would soon develop in the field of pre-medical students, since Selective Service has decided not to defer pre medical students after July 1. The need of a broad statement relative to the position of the A. M. A. in all affairs medical, was then emphasized, with particular reference to the role which the Federal Government should play in medical care. Dr. Paullin closed with an eloquent plea for unity of thought and unity of purpose among the ranks of physicians in supporting the principles of the A. M. A. His address was well received although to some it appeared somewhat too conservative.

Herman Kretschmer, President-elect of the A. M. A., was the next speaker. He mentioned various phases of medical practice. His remarks concerning the A. M. A. were in line with those which he gave recently at a meeting of the Columbia Medical Society — a blanket endorsement of all that had been done.

Following Kretschmer came the man whom I have found the most forceful speaker in the medical profession today, Frank Lahey of Boston, Chairman of Procurement and Assignment. In detail, he gave the story of what had happened to the pre-medical student, how he would no longer be deferred, the efforts which had been made to change his status, and the results which might ensue in the field of medical education and general medical care if a change was not made immediately.

As a result of the recent action of Selective Service and of Dr. Lahey's talk, a strong resolution was passed asking that the President and Congress take immediate steps to correct the situation.

Next in order came the reports of the Secretary, Olin West, the Board of Trustees, the Judicial Council, the Council on Medical Education and Hospitals, the Council on Scientific Assembly, the Council on Medical Service and Public Relations, the Committee on War Participation, and the Committee on Post War Medical Service. Most of these reports had been printed in the Handbook and were read by title only. In some instances a supplementary report was read and this was particularly true of the newly created Council on Medical Service and Public Relations who revised and amplified the present platform of the A. M. A., attempting to bring it up-to-date and in line with the times. I have an idea that we will hear a good bit of this new platform from now on.

Under the head of new business, resolutions were introduced from the floor, and the first one to be presented was our own resolution relative to reapportionment of members. Tom Pitts was right on the job. Other resolutions were introduced and each was referred to an appropriate committee.

The House of Delegates finally recessed at 2:40 P. M.—and it was most welcome. The chairs were

beginning to get hard and the pangs of hunger were annoying.

After lunch, I sat in on the meeting of the Reference Committee on Amendments to the Constitution and By-laws. The first matter discussed was a resolution on behalf of the physicians in the Veterans Administration, asking that they be given the privilege of becoming fellows of the A. M. A. At the present time they cannot become members or fellows since the vast majority are not eligible for membership in county and state associations. There was a great deal of interesting and illuminating discussion. Our resolution was finally considered and Tom Pitts and I both spoke in its behalf.

By the end of the day, we were all fagged and ready for a bit of relaxation and food. Buck Pressly, Tom Brockman of Greenville, President-elect of our Association, Lee Milford of Clemson, and I went out to the famous Kungsholm. For anyone who is planning a trip to Chicago, this should be put at the top of the "must" list. We were not only delighted with the food but were charmed with the Miniature Grand Opera Theatre on the fourth floor.

Back to the hotel at eleven P. M. and ready for bed after recording the day's doings in this travelogue.

Tuesday, June 13.

The morning session of the House of Delegates was devoted to hearing and passing upon the reports of the various Reference Committees. Certain things were evident as the reports were presented; the committees had given study to the various resolutions, they were usually very positive in their findings, the findings were all unanimous, and the final recommendations of the committees were adopted. That no minority reports were given was disappointing to me since it showed either a reluctance or a temerity on the part of some committee members to assert their opinions. Incidentally, our South Carolina resolution was quietly killed in a single sentence.

The House of Delegates had lunch together and the state secretaries tagged along to help the members eat.

After lunch, the House went into Executive Session to consider controversial matter. The first resolution received was from the National Medical Association (colored) asking for closer professional relationships between white and colored physicians, and also asking that the A. M. A. grant associate memberships to colored physicians. A message was sent back to the National Medical Association that this was a matter for the state associations to consider since membership in the A. M. A. was contingent upon membership in county and state organizations.

Several other matters were presented and discussed, but the one which produced the most interest and tension was the one from the California delegation asking that Olin West be made Secretary-Emeritus and that Morris Fishbein be replaced. It was divided into two parts for consideration. The proposal to make West Secretary-Emeritus was voted down without a dissenting voice. But the Morris Fishbein issue provoked considerable debate. Dwight L. Wilbur of California — one of the few delegates under 50 — presented the case for California and did it well. With no rancor or personal recriminations he stated the reasons for the resolution. Rising to defend Fishbein were Allen Bunce of Atlanta, Tom Cullen of Baltimore, W. A. Mulherin of Augusta, C. G. Mundt of Chicago, and C. G. Heyd of New York. Finally, Fishbein was called upon to make a statement if he so desired, and he told briefly of his 31 years connection with the A. M. A.—20 years as Editor. Henry Luce of Detroit moved that the vote be by secret ballot but after a rousing speech by E. H. Cary of Texas, the motion was lost. (Incidentally, the speaker of the House, Harrison Shoulders of Nashville, slipped up on this one. A motion to vote by ballot is not debatable.) A standing vote was taken and the motion lost by 144 to 9. I have an idea that the vote would have been different if it had been made by ballot.

The entire procedure convinced me of this—The present House of Delegates want to retain Morris Fishbein in his present position. Whether the House expresses the position of the hundred thousand members of the Association is open to discussion.

At 4:30, I joined Buck Pressly at a meeting of Procurement and Assignment. We were told that 54,000 physicians are now in the armed forces and that no further recruiting of physicians is contemplated. Considerable discussion was given to the question of pre-medical students in the light of the recent ruling that no further deferments would be given these boys after July 1. Attention was directed to the internes now serving in hospitals who had been disqualified for physical reasons. Under the new physical standard schedule some of these will be available for limited military duty or for service with the Veterans Administration—and this might have a serious effect on the staffs of many hospitals. The problem of relocating physicians was also mentioned but when there are no physicians to relocate—as is true in South Carolina today—there isn't much to be said or done.

The evening was devoted to an informal dinner meeting of state secretaries, editors, and executive secretaries and it was a delightful and informative affair. In addition to discussing advertising problems, we were privileged to hear talks by Ben Reed of California, Secretary of the United Public Health League, who has spent the last eight months in Washington; Joe Lawrence, Executive Officer in charge of the newly created A. M. A. office in Washington; Watterson, Executive Secretary of the (Gary, Indiana) Association of American Phy-

sicians and Surgeons; and Murray Reese, head of a large national advertising agency.

Among the things which we were told were: a move appears to be on foot by the C. I. O. and others to start a new drive in behalf of the Wagner Bill, there are definite indications that the principles of the Wagner Bill will be injected as an issue into the political campaign this fall, the average lay person doesn't know what the medical profession is doing or what it wants. "The average medical society does not compare with the smallest labor union in organization. Practically no dues are paid and little activity is in evidence." All of which gives plenty of food for thought.

Finally back to the hotel at eleven o'clock to write this day's report and to bed at midnight. I did stop writing long enough to call Buck Pressly and make plans to attend the ball game the next night.

Wednesday, June 14.

There being no business sessions today, I decided to investigate the scientific part of the meeting. The morning was spent browsing through the commercial exhibits, talking to friends and investigating new medical equipment, drugs, etc. There are so many exhibits and so much to see that it was only possible to hit the high spots. I thoroughly enjoyed the art exhibit of physician's handwork—put on by Mead Johnson & Company. Paintings, etchings, photographs, metalwork, wood-carving — it is surprising how many physicians have the artistic hobby and how good many of them are. I saw no work from the hand of a South Carolina Physician and it is regretable for I know of several of our members who are experts with a camera.

After lunch I went to the section on Pediatrics and was surprised at the large attendance. Sako and his colleagues of New Orleans gave their findings in the early immunization against pertussis (having vaccinated over 1,000 infants under two months of age) and advised its widespread use at that early age. They used the alum precipitated preparation. Louis Sauer of Evanston, Ill., discussed the paper and advised caution. He has found these early immunizations less permanent in their protection than vaccination at five to six months. He protested against the use of the mixed whooping cough-diphtheria toxoid. Shapiro of Minneapolis was next and gave a discussion on the pre-operative diagnosis of patent ductus arteriosis, stressing the cardinal signs: machinery murmurs, pulmonic thrill, high pulse pressure, and normal electrocardiogram. The next two papers dealt with precocious skeletal development in children and certain mental hygiene aspects of pediatrics—nothing very exciting in either one.

The final discussion which I heard was concerned with the treatment of poliomyelitis. Albert Key gave an account of the type of treatment which we were taught in medical school twenty years ago and indicated that he found no value in the Kenny method of care. In the discussion, Milaud Knapp of Minneapolis spoke out for the advantages of heat as taught by Sister Kenny and took issue with various statements of Key. John A. Toomey of Cleveland, a clear and original thinker, argued for the care of each case as a distinct entity and stated that no one routine type of treatment was applicable for all. He believed that hot packs were of value in relieving pain and in protecting the muscles.

After a quick tour of the scientific exhibits I came back to the hotel, had something to eat, and then joined Buck Pressly and Lee Milford. We spent an extremely interesting and instructive evening at Comisky Park where the league leading St. Louis Browns drubbed the Chicago White Sox 10-3.

Thursday, June 15.

One of the pleasures and responsibilities of a trip is getting something to take back to the youngsters at home, so I spent the early part of the morning at Marshall Fields and at a sporting goods store. Following this, I attended the final session of the House of Delegates. After finishing up with miscellaneous business, officers were elected for the coming year. Roger Lee, Chairman of the Board of Trustees, was made President-elect by acclamation. His choice appeared to be extremely popular. Stanley Segars of Texas was elected Vice President, and Olin West was re-elected Secretary. Louis Bauer, Chairman of the Council on Medical Service and Public Relations was elected to succeed Roger Lee on the Board of Trustees.

The afternoon was spent in the section on Pediatrics listening to a symposium on abdominal pain in children. The best paper, and the most practical, was given by Joseph Brenneman, grand old man of Pediatrics, now retired and living in Vermont.

Tonight, in company with Hall Farmer, Pediatrician from Macon, Georgia, and his wife, I attended the annual banquet for the members of the Pediatric Section. This was followed by a floor show—put on by Mead Johnson and Company—which was the best I have ever seen.

Friday, June 16.

The morning was spent in the section on medicine. Colonel Paul Holbrook discussed acute rheumatic fever in the Army. He was followed by Commander Alvin Coburn who gave the results of his use of sulfadiazine as a prophylactic against bacterial infections in the upper respiratory tract. He showed, rather conclusively, the value of a daily dose (0.5 to 1.0 gm) of sulfadiazene in preventing or aborting epidemics of streptoccic throat infection.

Colonel Julien Benjamin and Dr. John R. Paul of New Haven next discussed postvaccinal (yellow fever) hepatitis and infectious hepatitis in the Mediterranean Area — and the similarity between the two conditions is remarkable.

The last half of the program consisted of a

symposium and panel discussion on vitamins, amino-acids and enzymes. Morris Fishbein was the moderator and those who participated were: Emmet Holt of Baltimore, William Govier of Winston-Salem, Elmer Sevringhaus of Madison, Wis., A. J. Carlson of Chicago, and Tom Spies of Birmingham. The amino acids were entirely over my head, but the rest was understandable and instructive. The observation of Govier that thiamin chloride was of value in the treatment of shock should be welcome news to surgeons.

After packing—and it was no easy task to get a baseball mitt and other articles tucked away—I checked out at the hotel and headed for the station and home.

Perhaps my impressions of the meeting as a whole might be of interest to some. Scientifically, it was good. There were good papers and plenty of information was available to those who went after it. Socially, it was enjoyable but not up to the Southern—where there are not so many physicians distributed in so many hotels and where one sees more personal friends.

But what of the A. M. A. in the broad field of social medicine? The A. M. A. is still highly conservative and is still waging a great defensive battle — but there is evidence of a growing desire for aggressive action. Of this I am convinced. There will be no major change in the actions of the A. M. A. until there is a marked change in the present personnel in the House of Delegates. The A. M. A. will change and become more progressive when the constituent state associations—particularly the larger ones with greater voting power—send new men with new ideas, who will make their opinions known and vote accordingly.

Julian P. Price
Secretary

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THE CANDIDATES SPEAK

On June 7, the Secretary sent a letter to each of the candidates for the office of senator from South Carolina, in which he offered the columns of this Journal for an expression of views relative to national affairs, with particular reference to the Wagner Bill. As replies to this letter are received they will be printed. Those which have already come to hand are as follows:

Dr. Julian P. Price
S. C. Medical Assoc.
Florence, S. C.
Dear Dr. Price:

I have your letter of June 7th concerning the Wagner-Murray-Dingell bill.

I wish to assure you that I am opposed to the passage of this measure and have expressed myself over the radio and through the newspapers in regards to my opposition to the passage of this bill.

Thanking you for this opportunity of service, I am

Sincerely yours,
Olin D. Johnston,
Governor.

P. S. I am enclosing a copy of letter you wrote me sometime ago and would appreciate it if you would use the statement I made at that time.
June 8, 1944

GOVERNOR JOHNSTON'S OPINION

The Wagner-Murray Bill was just another attempt to encroach upon the rights of the States and an attempt to control the people of our State from a centralized authority in Washington.

The Bill sets up a Surgeon General of the United States Army as a supreme dictator over the medical practice of the entire Nation. Under the Bill each doctor would be assigned to a certain territory and every person in this territory will of necessity be forced to use this doctor.

This Bill will destroy free enterprise and destroy initiative and there will be no incentive for a young man to enter the field of medicine with the feeling that he is limited in his accomplishments.

Medical science has done wonders for the human race under free enterprise. I do not think that medical science can continue to grow if it is bound by governmental red tape.

It is unfair to the doctors and nurses and pharmacists who are serving in this war and who are now on the battlefield to try to put over a bill that will hamper them in the post war period. Most of these doctors and nurses who are serving in our Army and Navy at this time are looking forward to the day of peace. They are being regulated and disciplined because of the necessity of war, but they are looking forward with anticipation to the day when they can return to their respective communities and enjoy the free American life, and I see no reason for the American people to try to regulate every activity of its population by Federal control.

The Wagner-Murray bill does not recognize the need for suitable food, sanitary housing and improvements necessary to the prevention of disease and the promotion of health.

When I wish to seek a doctor for my family, I do not want to anticipate the Federal Government or any Surgeon General telling me who shall serve me or my family during illness. The right of choice of free will is endangered by such a measure.

Olin D. Johnston
Governor

September 28, 1943
Columbia, S. C.

June 19, 1944.

Dr. Julian P. Price, Secretary-Editor
Journal of the South Carolina Medical Association,
Florence, S. C.

Dear Doctor Price:

I thank you very much for your very kind letter of June 7th, extending to me the columns of the Journal of the South Carolina Medical Association for expression of my views on federal questions, particularly on the Wagner-Murray-Dingell or so-called socialized medicine bill, and I would have replied more promptly except for the fact that I have been almost continuously out of town since your letter was received at my office, being away most of last week on the campaign for the Senate which is now in progress, and this is the very first opportunity I have had to reply to your letter.

I am grateful indeed for the opportunity to make a statement in the Journal at this time on the bill above mentioned, and I should also like when I am not so pressed for time as I am at present, to comment in the Journal on other matters pertaining to the vast federal bureaucracy which is regimenting our people and destroying every vestige of state and individual rights, uprooting the system of government that made this country and converting the republic into a socialized totalitarian state.

This so-called socialized medicine bill is the acme of tyranny. No such iniquitous thing can be imposed on our people. In a pre-campaign speech here in Sumter on May 15th of this year, denouncing this unthinkable bill, I stated: "I want to say to the people, including the doctors of this state, that they need not worry. We are not going to have any socialized medicine—not if you send Gus Merrimon to the Senate. If we do, at least one member of

that body, exhausted and withered and dead from exertions that the human machine could not stand, made in defense of the highest and one of our most sacred rights, will no longer need the administrations of his own family doctor." That statement expresses in few words exactly how I feel about this revolting measure. Whenever the time comes that the politicians dominate the medical profession and the hospitals, whever we are denied the right to choose our own physicians in times of sickness and distress, not only will medical service deteriorate, but the last vestige of human liberty will be gone.

Sincerely yours,
A. S. Merrimon.

June 21, 1944.

Sec. Julian P. Price, M.D.,
Florence, S. C.

Dear Sir:—

Thank you for your request for an expression from me, as a candidate for the United States Senate, upon medical problems, the Wagner Bill, etc.

I fully realize from my medical practice the great need for more adequate medical care, especially in the rural districts. When I was chairman of the Committee on Medical Economics of The South Carolina Medical Association, in 1943, we made a rather full report, which you have.

In general, and very briefly, I would say that I favor keeping the care of the indigent in the hands of the private physicians, and keeping the whole matter out of the hands of the politicians. The private physicians, being already established, with overhead expenses being paid anyway, can afford to attend the poor more economically than public health doctors can be provided. And the necessary elements of competition and initiative will be retained to help insure good medical attention. I do not feel that the doctors should have to continue to bear such a burden of the care of the sick as they have in the past, and are now doing. I think every patient should be able, so far as is possible, whether free or pay, to have his own choice of doctors.

Group Health Insurance, and Hospital Insurance should be encouraged and perfected.

Keep medical care and medical education out of politics.

A workable plan to encourage doctors to practice in rural districts.

With best wishes, Iam,

Yours very sincerely,
Carl B. Epps, M.D.,

Candidate for the United States Senate.

IF our Service Representatives cannot get to see you as regularly and frequently as desired, please write, wire or phone and we will give you prompt, courteous and intelligent service.

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July 5, 1944.

Dr. Julian P. Price, Secretary-Editor,
South Carolina Medical Association,
Florence, S. C.

My Dear Dr. Price:

Absence from the office has delayed my answer to your letter of June 7th. I do not favor the Wagner-Murray Dingell bill. The family needs its chosen physician. There are some things the Government cannot do better. I believe generally "the least governed are the best governed."

With best wishes, I am

Yours very truly,
John M. Daniel.

Pathological Conference, Medical College of the State of South Carolina

KENNETH M. LYNCH, M.D., PROFESSOR OF PATHOLOGY

ABSTRACT NO. 514

Student L. C. Bailes (presenting):

History: 66 year old white cabinet maker developed bronchitis on April 1, 1943. On April 5th he developed a severe pain in right upper quadrant and when seen on April 6th he had severe pain in this region, with rigidity and had some nausea and vomiting. Also had cough. T-103°, P-110. Pain and rigidity subsided in three to four days, but temperature persisted for five days and on April 11th rose to 103-104°. Suggestion of pneumonia in lower lobe of right lung. Sulfadiazine given. On April 15th he developed a focal area of abdominal tenderness (1" in diameter in G-B area), fever returned and he was again given sulfadiazine. Temperature returned to normal in 24 hours. Because of general appearance (looked more ill than temperature and pulse indicated), lung findings and area of abdominal tenderness, hospitalization ordered on April 18th.

On admission he had a rectal temperature of 108° and pulse 130. Respirations were rapid and shallow and he appeared acutely ill. Limited excusion of diaphragm on right side. Lungs clear to percussion but friction rubs heard in left axilla. Marked abdominal distention with generalized tenderness, most marked in right hypochondrium where there is also marked rigidity. Palpable mass over G-B area.

Laboratory: Urinalysis showed Sp. Gr. of 1.020 and 3 plus albumin. WBC 14,600 with 91% Polys., Hb. 81%, Blood sugar 148 mgs. Urea N. 30 mgs.

Course: Patient had chill and temperature dropped to 99 and then rose to 105°. Dulness and modification of breath sounds developed in base of righ. lung. Generalized abdominal pain, most severe to right of epigastrium. Temperature remained elevated to 103-105° and abdominal distention, pain and tenderness persisted. Died five days after admission.

Dr. Prioleau (conducting): Mr. Boatwright, what is your analysis of the case?

Student Boatwright: There is apparently an acute inflammatory process in the abdomen. All the signs and such symptoms as high fever, abdominal distention, nausea and vomiting point to this. The palpable mass and tenderness in the gallbladder area suggest suppurative cholecystitis, probably with eventual abscess formation about that organ. Terminally there seems to have been contamination of the peritoneal cavity with generalized peritonitis. One must also consider a subdiaphragmatic or liver abscess. The limited movement of the diaphragm is certainly a point in that direction. The friction rubs are of little help, particularly in their location, unless he had a complicating bronchopneumonia.

Dr. Prioleau: What would be the origin of a liver abscess?

Student Boatwright: It might be a complication of intestinal amebiasis. It is more likely to be pyogenic in nature, however, and to have come from some inflamed vicus such as the appendix. Inflammatory exudate may extend upward along the lateral abdominal gutter, and form an abscess immediately beneath the liver or between the diaphragm and the liver. This might be particularly likely if the appendix was retrocecal in position.

Dr. Prioleau: What is the most likely route by which infection reaches the liver?

Student Boatwright: By the portal venous system.

Dr. Prioleau: The usual symptoms of appendicitis are lacking, so that it is difficult to blame the appendix for the trouble. The pulmonary findings are also not yet clear. Mr. Boyter, what do you think about the case?

Student Boyter: I think he had some acute inflammatory disease of the abdominal cavity or thorax. The most likely of these seem to be liver abscess, acute cholecystitis or suppurative involvement of the appendix that was bound down in the gallbladder area. The mass, localized tenderness and septic course make me favor liver abscess. It probably was situated in the right lobe of the liver, infection having reached there via the portal system. I am not sure of the primary site of infection. The patient seems to definitely have had peritonitis which probably resulted from perforation of the liver capsule by the abscess.

Dr. Prioleau: Mr. Boyter mentioned the possibility of some inflammatory process within the thorax. What do you think of that possibility, Mr. Brill?

Student Brill: It could give some of the abdominal symptoms, but not all of them. It was a suppurative process as indicated by the septic course. Pleurisy followed by an empyema might have been responsible, although pleural involvement so situated as to give right upper quadrant pain would very likely produce pain in the shoulder region. The friction rubs may have been produced by pulmonary embolism and infarction.

I believe the trouble was intra abdominal, however, and that suppurative cholecystitis is the most likely. In spite of the lack of history of previous attacks, cholelithiasis offers the best background for the present acute episode. The peritoneum may have been secondarily involved either due to rupture of gallbladder or by extension of bacteria through the necrotic wall. I think the sulfadiazine masks the clinical picture to some extent, because even when the pain subsided, the temperature and pulse remained elevated.

Dr. Prioleau: I am unable to fit everything together in this case. I am unable to explain the chest findings. Acute cholecystitis with pre-existing calculus and extension of the inflammatory process to the peritoneal cavity seems most probable. The omentum and intestine may have been matted about the gallbladder and thus accounts for the mass, as I would not expect a distended gallbladder in one that had been previously inflamed. I see no logical reason for a liver abscess.

Dr. Pratt-Thomas: The final pathological diagnosis is: *Appendicitis, Acute, receding with fecalith*

obstruction and perforation; Abscesses of liver; Peritonitis, Acute, Generalized; Congenital Anomaly of Cecum and Ascending colon.

Abnormal position of the cecum possess a high degree of practical surgical interest because of the difficulty in diagnosis and the complications they produce should appendicitis supervene.[1] This statement sums up the chief difficulty that this case presents from a clinical standpoint. The ascending colon was very short and it and the cecum were situated high in the abdomen immediately beneath the liver. The distal 7 cm. of the ileum was covered by a fold of parietal peritoneum so that it actually lay retroperitoneal. The appendix was posterior to the cecum and colon and adherant to their walls. It was sharply kinked upon itself in hair-pin fashion. Its tip showed greenish-grey discoloration and contained a small amount of purulent exudate and a sharp pointed angular fecalith. One point of this object had perforated the wall.

The liver was enlarged and its right lobe contained a massive abscess cavity filled with grayish black exudate and necrotic liver tissue with fecal odor. The abscess was situated in the anterior and inferior portion of the right lobe and its cavity was situated so closely to the surface that on manipulation its contents exuded through the thin rim of the liver tissue.

There was a generalized purulent peritonitis with multiple intra-abdnominal abscesses. The peritonitis has two possible modes of origin, either from extension of the periappendiceal inflammatory process, or by the escape of the contents of the liver abscess through the capsule. The latter seems most likely. The initial bout of the upper right quadrant pain was due to appendicitis. This subsided and then on April 11th the liver abscess probably developed as he showed a sudden sharp rise of temperature.

1. Callander, C. L.: Surgical Anatomy, ed. 2, W. B. Saunders Co., 1939.

BOOK REVIEWS

MEDICAL PHYSICS

By Otto Glasser, Ph.D., Head, Department of Biophysics, Cleveland Clinic Foundation; Professor of Biophysics, Frank E. Bunts Educational Institute; Consulting Biophysicist, University Hospitals of Cleveland, Cleveland, Ohio.
1790 pages: Chicago: The Year Book Publishers. 1944.

This is a book of some eighteen hundred pages and includes subject matter related to all the fields of a medical school curriculum; medicine, nuclear physics, physical chemistry, photography, biophysics and many others. It is, in a way, a kind of aborted hand-book. Topics are presented alphabetically, but under the table of contents one finds them arranged according to subjects.

The contributors, some two hundred of them, are all generally recognized as authorities in their respective fields. The author might in time be able to develop this volume into something as complete as *Abderhalden's "Handbuch, der biologische arbeitsmethoden."* It is a good reference for current methods and techniques. For example, if one would like information on the electron microscope, which has a resolving power of a hundred thousand times greater than that of the ordinary microscope, one finds it here. The more practical subjects, such as methods of air conditioning an operating room, are also included.

E. D. Bueker, Department of Anatomy, Medical College, Charleston, S. C.

MEDICAL DIAGNOSIS, APPLIED PHYSICAL DIAGNOSIS

By Roscoe L. Pullen, A.B., M.D.
W. B. Saunders Company, Philadelphia, Pa.

This splendid text constitutes a valuable working guide for both students and busy practitioners in the diagnosis of varied organic and functional disorders.

The subject matter is presented in systematic progression by areas, organs and systems, easily facilitating integration of interpretation of the components of medical, and surgical investigation. In addition, it includes representative expositions on the several specialties, medical, surgical, and psychiatric, together with fluent chapters on such vital topics as sterility, occupational injury, military problems and prognosis. Also, there is a separate chapter on diagnosis in infancy and childhood.

Contents and context are clear, specific and of reasonable brevity without loss of essential and factual detail.

This work may be warmly commended to physician and student as a profitable and interesting reference guide.

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NEWS ITEMS

Dr. J. W. Kitchin of Liberty and Pickens is now in the Armed Forces. He reported to Carlisle Barracks, Pennsylvania, for a six weeks training period and will then go to Fort Devens, Mass.

Major Frank P. Coleman, formerly of Columbia, has been made chief of surgical service at the McGuire General Hospital, Richmond.

Dr. John Fleming (Spartanburg) is now a Lieutenant Commander in the United States Navy.

Dr. Reyburn W. Lominack is now stationed at Lowell General Hospital, Fort Devens, Mass. Dr. Lominack is from Charleston.

Dr. K. L. Able has been elected Mayor of Leesville.

Dr. Allen C. Bradham has reported to Carlisle Barracks for training. Dr. Bradham practiced medicine in Anderson before entering the Army. His rank is Captain.

Dr. James McLeod of Florence was elected a delegate from South Carolina to the National Democratic meeting to be held in Chicago.

Friends of Dr. C. R. F. Baker, Sumter, S. C., will be glad to know that he is improving after undergoing an operation.

Major James T. Green, formerly of Columbia, has recently been at home on a short leave.

Dr. C. S. McCants of Winnsboro has opened a hospital in his home town. Such a hospital has been greatly needed in this community for some time.

Dr. V. P. Patterson, Chester, was elected President-elect of the South Carolina Hospital Association at a recent meeting.

Dr. D. L. Allen, Greer, S. C., expects to leave soon for the United States Army Medical Training School, Carlisle Barracks, Pa.

The following physicians from South Carolina attended the A. M. A. meeting in Chicago:
Dr. A. E. Baker, Charleston
Dr. W. T. Brockman, Greenville
Dr. R. L. Crawford, Lancaster
Dr. James T. Hardy, Winnsboro
Dr. F. B. Johnson, Charleston
Dr. F. E. Kredel, Charleston
Dr. W. H. Moncrief, State Park
Dr. T. A. Pitts, Columbia
Dr. W. H. Poston, Pamplico
Dr. W. L. Pressly, Due West
Dr. Julian P. Price, Florence
Dr. James J. Ravenel, Charleston
Dr. Paul W. Sanders, Jr., Charleston
Dr. Robert Taft, Charleston
Dr. P. M. Temples, Spartanburg
Dr. William Weston, Columbia,
Dr. D. O. Winter, Sumter
Dr. F. E. Zemp, Columbia
Dr. Charles E. Ballard, Beaufort
Dr. James A. Hayne, Columbia
Dr. Lee W. Milford, Clemson
Dr. James T. Quattlebaum, Columbia
Dr. H. C. Raysor, St. Matthews
Dr. W. J. Snyder, Jr., Sumter
Dr. J. Warren White, Greenville
Dr. Hugh E. Wyman, Columbia
Dr. J. P. Young, Jr., North Charleston

Dr. W. T. Brockman of Greenville, President-elect of the South Carolina Medical Association, was recently made a Fellow of the American Proctological Society. This is a high honor and one well deserved.

Dr. W. H. Poston of Pamplico was made an Associate Member of the American Proctological Society at a recent meeting of that Society.

Contributions

The following contributions for the Ten Point Program have been received from June 5th to June 25th:

Dr. A. P. McElroy, Union, S. C.	$15.00
Dr. A. R. Johnston, St. George, S. C.	15.00
Dr. D. F. Adcock, Columbia, S. C.	15.00
Dr. F. L. Mabry, Abbeville, S. C.	15.00
Dr. P. G. Jenkins, Charleston, S. C.	15.00
Dr. S. J. Blackmon, Kershaw, S. C.	15.00
Dr. W. A. Hart, Columbia, S. C.	15.00
Dr. C. A. Kinney, Florence, S. C.	15.00
Dr. R. M. Newsom, Ruby, S. C.	15.00
Dr. J. A. Johnson, Marion, S. C.	15.00
Dr. J. P. Cain, Mullins, S. C.	15.00
Dr. James McLeod, Florence, S. C.	25.00

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CORRESPONDENCE

Dr. Julian Price, Secretary & Editor
South Carolina Medical Association.
Florence, S. C.
Dear Julian:

Please extend my sincere thanks to the State Medical Association for bestowing on me the highest honor within the gift of my medical colleagues.

I will render all the time and service that war times will permit me to give, in an effort to more closely unite and organize our county societies. A live county society is the medical association at work, and it is our best weapon to prevent political socialized medicine by the Federal Government.

Sincerely yours,
Thomas Brockman

Dr. Julian Price
Florence, S. C.
Dear Dr. Price:

I have had many notes from local men practicing in the State who are not alumni of the Medical College and who seem to think that for that reason they are not eligible for membership in the Alumni Association of the Medical College of the State of South Carolina. However, on talking the situation over with Buddy Pope and Joe Waring, I find there is nothing in the constitution against their becoming members and so availing themselves of the opportunity of attending the Refresher Course. As I understand it, the only requisite for becoming a member and attending the Refresher Course and Banquet, is that one pay the necessary dues, tuition fees and Banquet charges. No formal written application is necessary.

If you see fit to publish this in an early issue of the Journal, perhaps it might clarify the situation for those concerned.

Thanking you for your courtesy in this matter and with kindest personal regards, I am

Sincerely,
R. W. Hanckel. M.D.

Dear Julian:

Dick Hanckel has called to my attention your letter concerning the status in our Alumni Association of graduates of other medical schools than our own. While I know of no official ru e on the subject, I have repeatedly heard various officers of the association state at annual meetings, that the association was more than happy to consider that any reputable physician who was interested was to be considered a member by adoption, and that he should participate in the business and development of the association. I am sure that we Alumni are more than anxious to have all interested physicians join us in furthering all phases of medical education in the state and I see no reason why they should not officially become actual members if they care to do so. This is only my personal opinion, but I think it might be taken at is face value until the Association can make some definite provision. At present the constitution says "there shall be one class of membership — every graduate or former student and all nurses — are members —," the reference being to those who have attended the College.

The Refresher course was originally proposed by the Alumni for the benefit of all the profession of the state, or indeed of any physician who cared to come. It has been supported enthusiastically and generously by a number of men who are not Alumni, and their encouragement has been very much valued. At the present time we are receiving contributions from many doctors of the state who are graduates of various medical schools, and we hope sincerely that their interest will continue and grow.

We have suggested to the Alumni and others certain *minimum* amounts as contributions to our funds —two dollars annual dues, five dollars toward the expenses of the "Refresher" course, three dollars for the Founders Day banquet. The last is a college function, but open to all interested physicians just as is the Refresher course. We hope that attendance this year will be large. Incidentally, it is not too early to make hotel reservations for the session on November 1st and 2nd.

I will be glad if you will explain these matters in The Journal, or publish this letter if you wish.

Sincerely yours,
J. I. Waring, M.D.
President Alumni Association.

Dear Dr. Price:

I would appreciate it if you would let the members of your department know of the following new policy established in regard to NEW BOOKS and Current Journals in the Library:

Henceforth, *New Books* will be placed on reserve for a month, so that every person may have an equal chance for perusal, before it is allowed circulation (either restricted or general). However, they may go out over night (5 P. M.—10 A. M.) or over the week-end (1 P. M. Sat.—10 A. M. Mon.)

When a book is received in the Library, which has been requested by a particular person, he will be notified of its receipt, the book will be held for him for two days, and he will be given the privilege of having the book out for a two-day interval. Then it will go on the month's reserve as outlined above.

In regards to Current Journals: the latest issue of each journal will be allowed only over night or over the week-end circulation until the next issue is received.

Very sincerely yours,
Annabelle W. Furman, Librarian.
Dr. J. I. Waring,
Chairman of the Library Committee

Dr. Julian P. Price, Editor
Journal of the South Carolina Medical Association
Florence, South Carolina
My Dear Dr. Price:

The National Naval Medical Center of Bethesda, Maryland is endeavoring to collect for its archives a complete set of commissions issued to Naval medical officers and signed by past Presidents of the United States.

There is a small nidus now at the Center and it is hoped to be able to build this up to completion. Through the Navy Department Library and the National Archives a few more have been located. I am wondering whether you would care to insert a small item in your "Journal" to this effect, with the idea that various libraries or individuals may have in their possession such old commissions and

would be willing to turn them over to the Center. If such are found and the owners are so generous, there could be no more fitting enshrinement to them than their use for this purpose.

Any assistance that you and the "Journal" can extend will be greatly appreciated by the Surgeon General.

With best regards.

Sincerely yours,
ROBERT C. RANSDELL,
Commander, (MC) USNR
Division of Publications

WOMAN'S AUXILIARY
SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. William H. Folk, Spartanburg, S. C. **Publicity Secretary: Mrs. J. C. Josey, Spartanburg, S. C.**

Mrs. William H. Folk

Just as the team of the aerial camera and the airplane is changing the entire tactics of modern warfare, physicians' wives and their access to authentic health facts may in their contacts with the public change its entire views in regard to various health problems.

The Woman's Auxiliary to the South Carolina Medical Association is beginning its twentieth year

of service, and stands ready to carry out suggestions and requests of the South Carolina Medical Association, also to act as an aid for families of physicians in military service.

By keeping in mind several great things; health education, thrift, cooperation, and others, the Woman's Auxiliary has become greater each year.

Let us keep in our hearts those great words of James Rowe;

"Give something to others each day of the year,
If only a handclasp, a look or a tear,
Whatever is given, if given in love,
The Master recordeth in heaven above."

Mrs. William H. Folk,
President.

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THE WOMEN'S FIELD ARMY SOUTH CAROLINA DIVISION

After more than two years of war everyone is looking forward to peace. All eyes are concentrated on our foreign battle front. Dramatic deeds of daring thrill us and help speed the Armistice. But simultaneously, with fighting on the foreign front to preserve the life of our nation, battles are being conducted on the home front to preserve the health of our people.

When War broke out some of us were faced with the problem whether to continue in the fight against cancer, or to resign and engage in some activity more closely related to the war effort. I think you will be convinced that the fight against cancer is most important, if I tell you some facts about this disease.

Cancer is second highest cause of death in the United States. It is said that 480,000 persons have cancer who will live only from one to three years. Of this number, 163,000 die annually. If "Treated in Time" approximately 100,000 die needlessly. It is the aim of the South Carolina Division to put on an educational program that will reach every home before 1945. Public education is the only way of beating the situation that now exists. Education is a slow—often thankless job. But someone has to do it. Who could do it better than those of us who are interested in the health of the nation? There is nothing dramatic about the fight against cancer. We need workers all over South Carolina. You will have the opportunity soon to help. We urge you to join in with these 250,000 women and help with the Women's Field Army.

The Women's Field Army is under the direct supervision of the Medical Association and the State Board of Health who are sponsoring the Cancer Control program in South Carolina. Dr. Kenneth M. Lynch is Executive Chairman, who with the following compose the Committee: Dr. Ben Wyman, Clinton; Dr. James Hayne, Columbia; Dr. G. S. T. Peeples, Columbia; Dr. W. S. Judy, Greenville; Dr. J. R. Young, Anderson; Dr. P. M. Temples, Spartanburg; Dr. E. E. Herlong, Rock Hill; Dr. James McLeod, Columbia; Dr. Floyd Rodgers, Columbia; and Dr. W. R. Wallace, Chester.

The Women's Field Army has for its main objective the education of lay people with respect to the native and early symptoms of cancer. The Field Army makes no attempt to give medical advice but seeks only to provide the public with a more intelligent view of the cancer problem. The activities of the organization have received the wholehearted endorsement of many national and state societies, including American Medical Association, The American College of Surgeons and the United States Public Health Service.

In 1938 the Congress of the United States designated April as "Cancer Control Month" and authorized the President to issue a proclamation to that effect. Each year the Women's Field Army conducts an intensive educational campaign and asks for memberships to increase the effectiveness of the program. All funds obtained during the enlistment drive are used to defray the expenses of the educational program for the year. All funds are used exclusively in the interest of Cancer Control.

The Campaign in South Carolina has not been reported in full but the counties heard from have either made or gone over their quota. Since this is the first such campaign put on in South Carolina we are very proud of the beginning.

Mrs. L. O. Mauldin, State Commander.

1943-44 REPORT OF STUDENT LOAN FUND

Gifts to the Student Loan Fund have been sent in by most of our Auxiliaries.

We do not have an applicant this year due to the fact that the men are in service of our country and the education financed by the United States government, therefore the loan is not needed for the duration. Seven men have been helped through medical college by the Student Loan Fund. Letters expressing deep gratitude and appreciation come from the men as they finish payments on loans, telling somewhat of the advantages of the opportunity of a medical education as afforded by the Student Loan Fund. All the men have entered the Armed

Forces as commissioned officers and all except one are on active duty—some are overseas. All except two have married. I can sincerely say that all Student Loan Fund recipients are doing their part to win the war, if one may judge from letters received.

It has been said that "Nobody grows old by merely living a number of years. People grow old by deserting their ideals."

The prime purpose of the Student Loan Fund is to help educate for a doctor the sons and daughters of physicians who are or have been members of the South Carolina Medical Association. We are confident that a good service has been rendered and that we can say "Well Done!" When the peace has been won and our boys still want to be doctors, will they need this Fund again? We believe they will and the Auxiliary voted unanimously to keep the Student Loan Fund as the objective and continue our gifts looking toward post war needs. All loans have been paid promptly and in full. The Treasurer, Mrs. T. A. Pitts, shows a total balance of $2,320.08. Most of this is invested in U. S. Government Bonds.

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Mrs. L. O. Mauldin, Chairman
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